STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: West Virginia

CASE MANAGEMENT SERVICES

A. Target Group: See Attachment

B. Areas of State in which services will be provided:

/X/ Entire State.

/ / Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

/ / Services are provided in accordance with section 1902(a)(10)(B) of the Act.

/X/ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services: See Attachment

E. Qualification of Providers: See Attachment

State/Territory: West Virginia

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

CASE MANAGEMENT SERVICES

A. Target Group:

To reimburse case management services for Medicaid-eligible pregnant women up to sixty days postpartum and children up to age 1.

D. Definition of Services:

Case management services are those services which will assist Medicaid-eligible recipients in this target group to gain access to needed medical, social, educational and other services. Activities to be undertaken by the Care Coordinator are as follows:

1. Assessment - based on the medical treatment plan established by the client's physician, the client and the Care Coordinator will develop a realistic goal. The client's situation will be evaluated and needed services identified.

2. Service Plan Development - the Care Coordinator in conjunction with the client will develop an action plan that specifies concrete activities which are to be completed so that the established agreed upon goals can be achieved. The Care Coordinator must react promptly to emergency situations which may jeopardize the goal of the Service plan.

3. Coordination and Referral - the Care Coordinator will locate resources or make referrals or arrangements for treatment and support services relative to the Service Plan. At times the Care Coordinator may necessarily act as a facilitator to resolve access problems that arise in implementing the Service Plan.

4. Follow up and Monitoring - the Care Coordinator will ensure appropriate quality, quantity and effectiveness of services in accordance with the Service Plan. The Care Coordinator will confer with the client and review the Service Plan periodically as determined by the Department for continuity of needs and services received.

E. Qualification of Providers:

Organizational providers of case management services for this target group are: local health departments as created in West Virginia Public Health Law, Chapter 16-2-1, 16-2-3, and 16-2A of the West Virginia Code; health centers as defined by U. S. Public Health Service Act 330, and any other organization which employs appropriately qualified individuals specified below and meets the criteria outlined herein. Qualified individuals who meet the criteria outlined herein may be enrolled as providers of case management services.

Individuals serving as case managers for this target group shall be persons licensed by the West Virginia Board of Social Work Examiners under Chapter Thirty, Article 30, of the Code of West Virginia; and West Virginia Board of Nurse Examiners.

All providers of case management services must meet the following criteria for specified subgroup or groups of the target population:

1. Demonstrated capacity to provide all core elements of case management services, including:

   a. Comprehensive client assessment;
   b. Comprehensive service plan development;
   c. Linking/coordination of services;
   d. Monitoring and follow-up of services; and
   e. Reassessment of the recipient's status and needs.

2. Demonstrated case management experience in coordinating and linking such community resources as required by the target population.

3. Demonstrated experience with the target population.

4. A sufficient number of staff to meet the case management service needs of the target population.

5. A physical location or place of service through which eligible individuals in target group will have access to case management services.

6. An administrative capacity to ensure quality of services in accordance with state and federal requirements.

7. Capacity to document and maintain individual case records in accordance with state and federal requirements.

CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible individuals living in the community who are at risk of loss of independent functioning due to disability, incapacity, or health related problems, and who require community support services in order to maintain their independent living status in the community. These are individuals who have health related problems which limit their ability to independently perform the necessary activities of daily living. Consequently, they require assistance in their own home in order to remain independent. The source of this determination is a patient care evaluation completed by the patient's physician. The patient care evaluation tool is the Medicaid form M-2. That medical evaluation is reviewed by an RN and an appropriate plan of care developed by the RN based on the physician's recommendations for community support for the patient.

Medicaid recipients receiving case management services under waivers granted through Section 1915(c) of the Social Security Act are excluded.

D. Definition of Services

Case management services are "those services which will assist Medicaid eligible recipients in the target group to gain access to needed medical, social, educational, and other services." Case management does not include the direct provision of medical or psychological services.

The case management services for this population will focus on assuring that the recipients have access to the appropriate medical, social, and other support services required to maintain them at the maximum independent status in the community.

The service needs of recipients will be determined through comprehensive assessments which, by definition, is the case manager's analysis of the recipient's current status and needs. the case manager's assessment does not duplicate or overlap assessments carried out by professional medical or mental health practitioners or facilities.

The targeted case management services performed for this target group do not duplicate or overlap the medical case management activities performed in the physician directed case management program PAAS. The two functions are fundamentally different in that the PAAS Program is basically a physician/recipient lock-in program, while the targeted case management service involves coordination of a range of community support services.

The goals of case management are to assure that eligible individuals have access to needed services and resources, that necessary evaluations are conducted for eligible recipients, individual program plans are developed and implemented, and a reassessment of recipients needs and service provision occurs on an ongoing basis and at regularly scheduled intervals. All of the above is consistent with 1902(a)(23) of the Act.

E. Qualification of Providers:

Providers of case management services must have a provider agreement with the Medicaid agency, must be enrolled as participating providers in Medicaid, and meet the criteria outlined below.

1. Demonstrate a capacity to provide all core elements of case management services including:

   * Comprehensive client assessment and service plan development

   * Linking/Coordination of services. (By coordination of services we mean assuring that services are appropriate to the clients' needs and that they are not duplicative or overlapping.)

   * Monitoring and follow-up services.

   * Reassessment of the recipients' status and needs.

2. Demonstrate case management experience in coordinating (see definition above), and linking such community resources as required by the target population.

3. Demonstrate an appropriate physical facility or place of service through which individuals in that target group will have access to case management services. This means that the case management provider must have facilities to house the individuals who will carry out the case management functions, provide for physical custody of case records, and a place where both the Medicaid agency and the client group will have access to case records and to the individuals performing case management services.

4. Demonstrate an administrative capacity to assure quality of services in accordance with state and federal requirements.

5. Demonstrate ability to assure referral processes consistent with 1902(a)(23), freedom of choice for providers.

6. Demonstrate financial management capacity and system that provides documentation of services and cost.

7. Demonstrate capacity to document and maintain individual case records in accordance with state and federal requirements.

Items one through seven above refer to requirements for case management provider agencies. There is nothing in this definition which would preclude an individual from being designated as a provider agency if that individual meets all of the requirements outlined above.

Individuals serving as case managers for this target group shall include persons licensed by the West Virginia Board of Social Work Examiners under Chapter 30, Article 30, of the Code of West Virginia.

Any person or entity meeting requirements for the provision of case management services who wishes to become a Medicaid provider of those services will be given the opportunity to do so.

F. Nonduplication of Payment

Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children under age 18 who: have been placed in the legal custody, guardianship, or physical custody of the West Virginia Department of Health and Human Resources; are in subsidized adoption; have been or are in danger of becoming abused or neglected; and children who have been adjudicated delinquent by a court of juvenile jurisdiction, but who are not incarcerated in a public institution.

The legal status of the children who are placed in Department custody, and the status of those who have been judged delinquent, will be determined through the county Circuit Court or the juvenile courts respectively. Those determinations will be made following court ordered evaluations performed by social workers in the West Virginia Department of Health and Human Resources, juvenile probation officers in the court system, or appropriate medical professional practitioners.

Medicaid recipients receiving case management services under waivers granted through Section 1915(c) of the Social Security Act are excluded.

D. Definition of Services

Case management services are those services which will assist Medicaid eligible recipients in the target group to gain access to needed medical, social, educational, and other services. The case management services will include interface with the juvenile justice and legal systems on the part of the case manager. The case management services will not include case management providers acting as legal representatives. Case management does not include the direct provision of medical or psychological services.

The service needs of recipients will be determined through comprehensive assessments which, by definition, is the case manager's analysis of the recipient's current status and needs in identification of appropriate resources. The case manager's assessment does not duplicate or overlap assessments carried out by professional medical or mental health practitioners or facilities.

The targeted case management services performed for this target group do not duplicate or overlap the medical case management activities performed in the physician directed case management program PAAS. The two functions are fundamentally different in that the PAAS Program is basically a physician/recipient lock-in program, while the targeted case management service involves coordination of a range of community support services.

The case management activities carried out under this authority will supplement but not duplicate activities required under the title XX approved state plan.

The goals of case management are to assure that eligible individuals have access to needed services and resources, that necessary evaluations are conducted for eligible recipients, that individual program plans are developed and implemented, and a reassessment of recipients' needs and service provision occurs on an ongoing basis and at regularly scheduled intervals. All of the above is consistent with 1902(a)(23) of the Act.

E. Qualifications of Providers

Providers of case management services must have a provider agreement with the Medicaid agency, must be enrolled as participating providers in Medicaid, and meet the criteria outlined below.

1. Demonstrate a capacity to provide all core elements of case management services including:

   * Comprehensive client assessment and service plan development

   * Linking/Coordination of services. Coordination of services is assuring that services are appropriate to the clients' needs and that they are not duplicative or overlapping.

   * Monitoring and follow-up services.

   * Reassessment of the recipient's status and needs.

2. Demonstrate case management experience in coordinating and linking such community resources as required by the target population.

3. Demonstrate an appropriate physical facility or place of service through which individuals in that target group will have access to case management services. The case management provider must have facilities to house the individuals who will carry out the case management functions, provide for physical custody of case records, and a place where both the Medicaid agency and the client group will have access to case records and to the individuals performing case management services.

4. Demonstrate an administrative capacity to assure quality of services in accordance with state and federal requirements.

5. Demonstrate ability to assure referral processes consistent with 1902(a)(23), freedom of choice for providers.

6. Demonstrate financial management capacity and system that provides documentation of services and cost.

7. Demonstrate capacity to document and maintain individual case records in accordance with state and federal requirements.

Items one through seven above refer to requirements for case management provider agencies. There is nothing in this definition which would preclude an individual from being designated as a provider agency if that individual meets all of the requirements outlined above.

Individuals serving as case managers for this target group shall include persons licensed by the West Virginia Board of Social Work Examiners under Chapter 30, Article 30, of the Code of West Virginia.

Any person or entity meeting requirements for the provision of case management services who wishes to become a Medicaid provider of those services will be given the opportunity to do so.

F. Nonduplication of Payment

Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.